SERVICES AGREEMENT

BETWEEN

HEALTHCARE DATA MANAGEMENT, INC.

AND

WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE AGENCY

Healthcare Data Management, Inc
555 Croton Road, Suite 350
King of Prussia, PA 19406

www.hdminc.com

SERVICES AGREEMENT

THIS HEALTH BENEFITS REVIEW SERVICES AGREEMENT (the "Agreement") is entered into as of the Effective Date set forth hereafter in this Agreement, by and between the West Virginia Public Employees Insurance Agency, an agency of the State of West Virginia (hereinafter referred to as "CLIENT"), and Healthcare Data Management, Inc., a Pennsylvania business corporation (hereinafter referred to as "HDM"). HDM and CLIENT are hereinafter referred to collectively as the "Parties");

WHEREAS CLIENT is an entity that provides health benefits to it's members.

WHEREAS HDM is a company that provides health care benefits review, analysis and related services as set forth in this Agreement.

NOW THEREFORE, the parties, in consideration of the mutual covenants and agreements set forth herein, do hereby agree as follows:

1. GENERAL DEFINITIONS

"ELIGIBILITY REVIEW AND DEPENDENT ELIGIBILITY AUDITING SERVICES" means, generally, those professional review services, consistent with accepted industry standards and practices, associated with the retrospective review and analysis of multiple years of CLIENT eligibility, documents pertaining to employee health benefits, in order to establish whether, and to the extent that, eligibility data and dependent eligibility status is accurate, appropriate, and otherwise consistent with appropriate administration and generally accepted and reasonable parameters.

2. HDM'S SERVICES AND OBLIGATIONS

HDM agrees to provide the services and carry out the following obligations:

2.1 **Audit.** HDM agrees to provide those Health Benefits Review Services set forth in **Exhibit 1** to this Agreement, which is hereby incorporated by reference into the terms of this Agreement, in accordance with: (i) all applicable local, state and federal laws and regulations; (ii) accepted industry standards, and (iii) the terms and conditions set forth in this Agreement. The **Exhibit 1** services are referred to hereinafter as the "Review Services". Unless otherwise contradicted by the terms of this Agreement the Exhibit 1 services are to be performed consistent with the HDM Proposal to the West Virginia Public Employees Insurance Agency dated March 13, 2009, which is incorporated herein by reference as Exhibit 5.

2.2 Performance Guarantees. HDM agrees that it will comply with the performance guarantees and penalties as set out in Exhibit 3 hereto, which is incorporated herein by reference.

2.3 Confidentiality. HDM acknowledges and agrees that the performance of Review Services involves access to and review of confidential and proprietary information and CLIENT accounting, auditing, billing, medical and other records and methodologies pertaining to its administrators, providers and employees. HDM agrees that all employees, consultants, subcontractors and/or assigns

designated by HDM to perform Review Services under this Agreement shall strictly maintain the confidentiality of all documents reviewed and comply with HIPAA guidelines. HDM further agrees and warrants that: (i) HDM has established effective policies and procedures to ensure protection of the confidentiality of all documents reviewed by its employees during the course of performing Review Services; and (ii) all employees, consultants, subcontractors and/or assigns designated by HDM to perform Review Services are familiar with such policies and procedures and will comply with and implement such policies and procedures in performing services throughout the term of this Agreement, and following termination of this Agreement. All of the provisions of this Section 2.2 shall survive termination of this Agreement.

2. 4 **HIPAA.** CLIENT and HDM agree to the terms of the Business Associate Agreement, which is located at http://www.state.wv.us/admin/purchase/vrc/WvBaaAgApproved.pdf and incorporated herein by reference and made a part of this Agreement as **Exhibit 2.2. 5 Conflict of Interest.** HDM represents that it does not have any conflicts of interest in performing services outlined in **Exhibit 1**.

2.6 HDM shall maintain appropriate policies of professional liability and general liability insurance in at least the amount of one million dollars per occurrence, each respectively.

3. CLIENT'S OBLIGATIONS.

CLIENT agrees either to timely and fully perform, or to have timely and fully performed by an authorized representative/agent, the following obligations:

3.1 **Administrative Functions.** CLIENT with the assistance of HDM will obtain data from the administrators and other documents necessary and as may be required to the administration and performance by HDM of its obligations under this Agreement.

3.2 **Processing Bills.** CLIENT shall pay HDM within thirty (30) days of receipt of invoice for all fees invoiced by HDM to CLIENT. Interest will be incurred on payments more than 30 days overdue consistent with the Prompt Pay Act of 1995 (W.Va. Code §5A-3-54).

3.3 **Payment for Services.** To pay HDM for services rendered in accordance with the provisions of this Agreement and **Exhibit 1**.

3.4 **Confidentiality and Intellectual Property Rights.** CLIENT acknowledges and agrees that the analytical methodologies, algorithms, program code, software, information, and reports employed and delivered by HDM in the performance of its Review Services constitute confidential and proprietary information which are the valuable, sole and exclusive business property of HDM and its subcontractors (hereinafter "Intellectual Property"). CLIENT agrees that all of its employees, consultants, subcontractors and/or assigns who may become apprised of HDM's Review Services or Intellectual Property under this Agreement shall strictly maintain the confidentiality of all information reviewed.

4. TERM AND TERMINATION.

4.1 Effective Date and Term. This term of this Agreement shall be one year, beginning June 15, 2009 (the "Effective Date") and can be renegotiated on an annual basis. Any services beyond the fiscal year are contingent upon funds being appropriated by the Legislature or otherwise being available for this service. If funds are not appropriated, the Agreement shall terminate without penalty on June 30 after which date, the Agreement becomes of no effect and is null and void. However, the PEIA agrees to use its best efforts to have the amounts contemplated under the Agreement included in its budget. Non-appropriation or non-funding shall not be considered an event of default.

4.2 Material Breach; Opportunity to Cure; Termination. CLIENT may terminate this Agreement effective immediately upon giving notice to HDM in the event of HDM's material breach of this Agreement, provided CLIENT has first provided HDM, pursuant to Section 5 below, with written notice containing specific details of the stated material breach and HDM has thirty (30) days to cure the same. Failure by HDM to cure the material breach during such thirty (30) day period will thereafter allow for termination of this Agreement by CLIENT and payment to HDM shall then be made pursuant to Subsection 4.3 below.

4.2 Termination Without Cause. CLIENT or HDM may terminate this Agreement, without cause, effective 30 days after written notice to the other party, provided pursuant to Section 5 below, and payment to HDM shall then be made pursuant to Subsection 4.3 below

4.3 Payment to HDM. CLIENT hereby agrees to pay HDM for all services rendered through and including the termination date.

5. NOTICES

5.1 Method of Delivery. Any notice to be given under this Agreement shall be in writing, addressed to the other party at the address listed in Section 5.2, or such other address as the party may designate by notice to the other party, and shall be deemed given by in-person hand-delivery, or by depositing such notice for delivery with the United States Postal Service, certified mail, return receipt requested, signature required, postage prepaid or by a recognized overnight delivery service such as Federal Express.

5.2 Addresses. The parties' names and addresses for purposes of giving notice under this Agreement shall be as follows:

If to CLIENT:

Mr. J. A. Haught, CPA
Chief Financial Officer
West Virginia Public Employees Insurance Agency
State Capitol Complex, Building 5, Room 1001
1900 Kanawha Boulevard, East
Charleston, West Virginia 25305-0710

If to HDM: Healthcare Data Management, Inc.
William Conlan, President
555 Croton Road, Suite 350
King of Prussia, PA 19406

6. INDEPENDENT CONTRACTORS; NO PARTNERSHIP OR JOINT VENTURE.

Neither party to this Agreement nor their respective employees or agents shall be deemed to be an agent, employee or servant of the other party. The parties acknowledge and agree that the relationship between them shall be that of independent contractors. Nothing in this Agreement or in **Exhibit 1** or any exhibit or related agreement hereto shall be construed or interpreted to form, establish or operate as a partnership or joint venture between HDM and CLIENT.

7. ENTIRE AGREEMENT/AMENDMENTS.

This Agreement and the Exhibits to this Agreement constitute the entire agreement between the parties. There are no agreements or understands between CLIENT and HDM which are not set forth in this Agreement or an Exhibit hereto and this Agreement replaces any and all such other agreements or understandings. No Amendment to this Agreement shall be effective unless in writing, signed by both parties, other than as provided in Subsection 7.1 herein below:

7.1 **Exception – Changes in Law.** In the event that CLIENT and/or HDM reasonably determine that applicable federal and/or state and/or local law or regulation requires amendment to this Agreement, then such party shall give the other thirty (30) days prior written notice as provided in Section 5 above, and upon expiration of such 30-day period, this Agreement shall be automatically amended to include the amendment set forth in such notice, as if the same had been accomplished in accordance with the amendment procedure set for in section 7 above.

8. INDEMNITY.

HDM agrees to indemnify, defend and hold harmless CLIENT of, for, from and against any and all claims, suits, demands, actions, settlements, judgments, penalties, actual, reasonable attorneys' fees and/or other monetary losses sustained by CLIENT as a result of errors or omissions by HDM in the performance of Review Services under this Agreement.

The terms of this Section 8 shall survive completion and/or termination of this Agreement.

9. FORCE MAJEURE.

Each Party's obligations under this Agreement shall be suspended to the extent that such party is hindered or prevented from performance (excluding economic payments or

performance) by labor disputes, lock-outs, acts of God, fires, storms, accidents, failure of a manufacturing, delivery or service intermediary to deliver any equipment, governmental regulations or interference, electronic terrorist attacks or actions, or any other cause to the extent not within the sole and exclusive control of the non-performing Party and In any such event, the non-performing party will be excused from any further performance or observance of the obligations so affected only for as long as such circumstances prevail and such party continues to use commercially reasonable efforts to recommence performance or observance as soon as practicable.

10. LAW APPLICABLE.

This Agreement and all covenants contained herein, shall be governed in all respects, whether as to validity, capacity, performance or otherwise, by the laws of the State of West Virginia.

11. PARAGRAPH HEADINGS.

The paragraph headings contained in this Agreement are for convenience only and in no manner shall be construed as part of this Agreement.

12. DISPUTE RESOLUTION.

The parties will attempt in good faith to resolve any controversy, dispute or claim arising out of or relating to this Agreement promptly by negotiations between senior executives and/or representatives of the parties who have authority to settle the controversy.

13. MISCELLANEOUS

a. Neither party may assign or transfer its rights or obligations under this Agreement without the prior written consent of the other, except that HDM may assign this Agreement to an affiliate or subsidiary with written consent of CLIENT provided that such assignment will not relieve HDM of any liability under this Agreement. This Agreement is binding upon and will inure to the benefit of the respective parties hereto and their successors and permitted assigns.

b. Except as otherwise provided for in this Agreement, this Agreement may be amended, supplemented, altered or modified only in writing signed by CLIENT and HDM.

c. Nothing in this Agreement, except as expressly stated herein, is intended to create any benefit for any third party. This Agreement may not be construed to create implied duties on any of the parties.

d. If any clause, paragraph, term, or provision of this Agreement shall be held or declared void or otherwise unenforceable by any arbitrator, court or other tribunal of competent jurisdiction, the same shall be deemed severed, and such holding or declaration shall have no effect upon this Agreement which shall otherwise continue in and be given full force and effect.

e. This Agreement may be executed simultaneously in a number of counterparts, each of which will be deemed an original, but all of which will constitute one and the same instrument.

IN WITNESS WHEREOF, intending to be legally bound hereby, in consideration of the promises and covenants exchanged herein and in the Exhibits hereto, the receipt and sufficiency of which is hereby acknowledged, each party to this Agreement has caused its duly authorized representative to sign this Agreement on its behalf below, effective as of the Effective Date set forth above in this Agreement.

CLIENT	**Healthcare Data Management, Inc.**
Name: [signature]	Name: [signature]
Title: DIRECTOR	Title: President
Date: 9/22/09	Date: 9/17/2009

EXHIBIT 1: SERVICES

This **Exhibit 1** is a part of the Dependent Eligibility Review Services Agreement dated June 15, 2009 ("Agreement"). In the event any term or condition of this Exhibit is in conflict with a term of the Agreement, the Agreement shall govern and control. Except as expressly modified by this Exhibit, all of the terms and conditions of the Agreement are unchanged and in full force and effect. All defined terms set forth in the Agreement are applicable to this Exhibit. HDM will perform a dependent eligibility audit of the health benefits plan for CLIENT. The service will include a Grace period, audit of all employees with one or more dependents and delivery of an audit report.

NOTE: HDM WILL PROPOSE INVOICE/FEE PROCESS 8/31

HDM's guarantee for savings from its audit for the CLIENT are limited to the Performance Guarantees set forth in Exhibit 3. HDM will report the service performance measurement at the time frame specified on the Performance Guarantee Table at the end of Exhibit 3. CLIENT will invoice HDM at based on the Time Frame HDM's fee for its audit is due whether or not such savings are realized. HDM may suspend its performance of services in the event that CLIENT fails to make a payment to HDM when due.

EXHIBIT 2

BUSINESS ASSOCIATE AGREEMENT

WV STATE GOVERNMENT

HIPAA BUSINESS ASSOCIATE ADDENDUM

This Health Insurance Portability and Accountability Act of 1996 (hereafter, HIPAA) Business Associate Addendum ("Addendum") is made a part of the Agreement ("Agreement") by and between the State of West Virginia ("Agency"), and Business Associate ("Associate"), and is effective on the date of execution of a binding agreement with the Agency.

Whereas it is desirable, in order to further the continued efficient operations of Agency to disclose to its Associate certain information which may contain confidential individually identifiable health information (hereafter, Protected Health Information or PHI); and

Whereas, it is the desire of both parties that the confidentiality of the PHI disclosed hereunder be maintained and treated in accordance with all applicable laws relating to confidentiality, including the Privacy and Security Rules, and the parties do agree to at all times treat the PHI and interpret this Addendum consistent with that desire.

NOW THEREFORE; the parties agree that in consideration of the mutual promises herein, in the Agreement; and of the exchange of PHI hereunder that:

1. Definitions.

a. Terms used, but not otherwise defined, in this Addendum shall have the same meaning as those terms in the Privacy and Security Rules.

b. Privacy Rule. Privacy Rule means the Standards for Privacy of Individually Identifiable Health Information found at 45 CFR Parts 160 and Part 164, Subparts A and E, as amended.

c. **Security Rule.** Security Rule means the Standards for the security of electronic protected health information found at 45 CFR Part 164, Subpart C, as amended.

d. Security Incident. Any known successful or unsuccessful attempt by an authorized or unauthorized individual to inappropriately use, disclose, modify, access, or destroy any information.

2. PHI Disclosed; Permitted Uses.

a. PHI Described. PHI disclosed by the Agency to the Associate, PHI created by the Associate on behalf of the Agency, and PHI received by the Associate from a third party on behalf of the Agency are disclosable under this Addendum. The disclosable PHI is limited to the minimum necessary to complete the tasks, or to provide the services, associated with the terms of the original agreement.

b. **Purposes.** Except as otherwise limited in this Addendum, Associate may use or disclose the PHI on behalf of, or to provide services to, Agency for the purposes necessary to complete the tasks, or provide the services, associated with, and required by the terms of the original agreement, if such use or disclosure of the PHI would not violate the Privacy or Security Rules or applicable state law if done by Agency or violate the minimum necessary policies and procedures of the Agency.

3. **Obligations of Associate.**

a. Stated Purposes Only. The PHI may not be used by the Associate for any purpose other than stated in this Addendum or as required or permitted by law.

b. **Limited Disclosure.** The PHI is confidential and will not be disclosed by the associate other than as stated in this Addendum or as required or permitted by law.

c. **Safeguards.** The Associate will use appropriate safeguards to prevent use or disclosure of the PHI except as provided for in this Addendum. This shall include, but not be limited to:

(i) Limitation of the groups of ils employees or agents to whom the PHI is disclosed to those reasonably required to accomplish the purposes stated in this Addendum, and the use and disclosure of the minimum PHI necessary;

(ii) Appropriate notification and training of its employees or agents to whom the PHI will be disclosed in order to protect the PHI from unauthorized disclosure;

(iii) Maintenance of a comprehensive written PHI privacy and security program that includes administrative, technical and physical safeguards appropriate to the size, nature, scope and complexity of the Associate's operations.

d. Compliance With Law. The Associate will not use or disclose the PHI in a manner in violation of existing law and specifically not in violation of laws relating to confidentiality of PHI, including but not limited to, the Privacy and Security Rules.

e. Mitigation. Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Associate of a use or disclosure of the PHI by Associate in violation of the requirements of this Addendum.

f. Documentation. Associate agrees to document disclosures of the PHI and information related to such disclosures as would be required for Agency to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR §§ 164.528 and 164.316. This should include a process that allows for an accounting to be collected and maintained by Associate and its agents or subcontractors for at least six (6) years from the date of disclosure, or longer if required by state law. At a minimum, such documentation shall include:

(i) the date of disclosure;
(ii) the name of the entity or person who received the PHI, and if known, the address of the entity or person;
(iii) a brief description of the PHI disclosed; and
(iv) a brief statement of purposes of the disclosure that reasonably informs the Individual of the basis for the disclosure, or a copy of the Individual's authorization, or a copy of the written request for disclosure.

g. Accounting Rights. Within ten (10) days of notice of a request for an accounting of disclosures of the PHI, Associate and its agents or subcontractors shall make available to Agency the documentation required to provide an accounting of disclosures to enable Agency to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR §164.528.

h. Access to PHI. Associate shall make the PHI maintained by Associate or its agents or subcontractors in Designated Record Sets available to Agency for inspection and copying within ten (10) days of a request by Agency to enable Agency to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR § 164.524.

I. Amendment of PHI. Within ten (10) days of receipt of a request from Agency for an amendment of the PHI or a record about an individual contained in a Designated Record Set, Associate or its agents or subcontractors shall make such PHI available to Agency for amendment and incorporate any such amendment to enable Agency to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR § 164.526.

j. Retention of PHI. Notwithstanding section 4.a. of this Addendum, Associate and its subcontractors or agents shall retain all PHI pursuant to state and federal law and shall continue to maintain the PHI required under Section 3.f. of this Addendum for a period of six (6) years after termination of the Agreement, or longer if required under state law.

k. Agents, Subcontractors Compliance. The Associate will ensure that any of its agents, including any subcontractors, to whom it provides any of the PHI it receives hereunder, or to whom it provides any PHI which the Associate creates or receives on behalf of the Agency, agree to the restrictions and conditions which apply to the Associate hereunder.

l. Amendments. The Associate shall make available to the specific individual to whom it applies any PHI; make such PHI available for amendment; and make available the PHI required to provide an accounting of disclosures, all to the extent required by 45 CFR §§ 164.524, 164.526, and 164.528 respectively.

m. Federal Access. The Associate shall make its internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by the Associate on behalf of the Agency available to the U.S. Secretary of Health and Human Services consistent with 45 CFR § 164.504.

n. Security. The Associate shall take all steps necessary to ensure the continuous security of all PHI and data systems containing PHI, and provide data security procedures for the use of the Agency at the end of the contract period. These steps shall include, at a minimum, the requirements contained in the West Virginia Office of Technology Policy No. WVOT-PO1001 (1-18-07) which may be found at:
http://www.state.wv.us/ot/PDF/Document_center/SecurityPol0107.pdf

o. Notification of Breach. During the term of this Agreement:

i. The Associate shall notify the Agency immediately by telephone call plus e-mail or fax upon the discovery of breach of security of PHI, where the use or disclosure is not provided for by this addendum of which it becomes aware, if the PHI was, or is reasonably believed to have been, acquired by an unauthorized person; or within 24 hours by e-mail or fax of any suspected security incident, intrusion or unauthorized use or disclosure of PHI in violation of this Agreement and this Addendum, or potential loss of confidential data affecting this Agreement. Notification shall be provided to the Agency contract manager (see www.state.wv.us/admin/purchase/vrc/agencyli.htm) and the Office of Technology Help Desk at (304) 558.9966; (877) 558.9966 (Toll Free); or servicedesk@wv.gov.

ii. The Associate shall immediately investigate such security incident, breach, or unauthorized use or disclosure of PHI or confidential data. Within 72 hours of the discovery, the Associate shall notify the Agency contract manager, and the Office of Technology Help Desk of: (a) What data elements were involved and the extent of the data involved in the

breach; (b) A description of the unauthorized persons known or reasonably believed to have improperly used or disclosed PHI or confidential data; (c) A description of where the PHI or confidential data is believed to have been improperly transmitted, sent, or utilized; (d) A description of the probable causes of the improper use or disclosure; and (e) Whether any federal or state laws requiring individual notifications of breaches are triggered.

iii. All associated costs shall be borne by the Associate. This may include, but not be limited to costs' associated with notifying affected individuals.

p. **Assistance in Litigation or Administrative Proceedings.** The Associate shall make itself and any subcontractors, employees or agents assisting Associate in the performance of its obligations under this Agreement, available to the Agency at no cost to the Agency to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against the Agency, its officers or employees based upon claimed violations of HIPAA, the HIPAA regulations or other laws relating to security and privacy, which involves inactions or actions by the Associate, except where Associate or its subcontractor, employee or agent is a named adverse party.

4. Termination.

a. Duties at Termination. Upon any termination of the underlying agreement, if feasible, the Associate shall return or destroy all PHI received from, or created or received by the Associate on behalf of the Agency that the Associate still maintains in any form and retain no copies of such PHI or, if such return or destruction is not feasible, the Associate shall extend the protections of this Addendum to the PHI and limit further uses and disclosures to the purposes that make the return or destruction of the PHI infeasible. This shall also apply to all agents and subcontractors of Associate. The duty of the Associate and its agents and subcontractors to assist the Agency with any HIPAA required accounting of disclosures survives the termination of the underlying agreement.

b. Termination For Cause. Agency may terminate the underlying agreement if at any time it determines that the Associate has violated a material term of the agreement or this Addendum. Agency may, at its sole discretion, allow Associate a reasonable period of time to cure the material breach before termination.

c. Judicial or Administrative Proceedings. The Agency may terminate this Agreement if the Associate is found guilty of a criminal violation of HIPAA. The Agency may terminate this Agreement if a finding or stipulation that the Associate has violated any standard or requirement of HIPAA, or other security or privacy laws is made in any administrative or civil proceeding in which the Associate is a party or has been joined.

d. Survival. The respective rights and obligations of Associate under Section 3.j. and 3.o. of this Addendum shall survive the termination of the underlying agreement.

5. General Provisions/Ownership of PHI.

a. Retention of Ownership. Ownership of the PHI resides with the Agency and is to be returned on demand.

b. **Secondary PHI.** Any data or PHI generated from the PHI disclosed hereunder which would permit identification of an Individual must be held confidential and is also the property of Agency.

c. Electronic Transmission. Except as permitted by law or this Addendum, the PHI or any data generated from the PHI which would permit identification of an Individual must not be transmitted to another party by electronic or other means for additional uses not authorized by this Addendum or to another contractor, or allied agency, or affiliate without prior written approval of Agency.

d. No Sales. Reports or data containing the PHI may not be sold without Agency's or the affected Individual's written consent.

e. No Third-Party Beneficiaries. Nothing express or implied in this Addendum is intended to confer, nor shall anything herein confer, upon any person other than Agency, Associate and their respective successors or assigns, any rights remedies, obligations or liabilities whatsoever.

f. Interpretation. The provisions of this Addendum shall prevail over any provisions in the Agreement that may conflict or appear inconsistent with any provisions in this Addendum. The interpretation of this Addendum shall be made under the laws of the state of West Virginia.

g. Amendment. The parties agree that to the extent necessary to comply with applicable law they will agree to further amend this Addendum.

h. Additional Terms and Conditions. Additional discretionary terms may be included in the release order or change order process.

APPROVED AS TO FORM THIS 20th
DAY OF December, 2007
DARRELL V. McGRAW, JR.
ATTORNEY GENERAL
BY. Dawn E Warfield
DEPUTY ATTORNEY GENERAL

1.1.

1.2. Use and Disclosure of PHI to Provide Services. The HDM will not use or further disclose PHI (as such term is defined in the HIPAA Privacy Rule) other than as

Exhibit 3 – Performance Guarantees

On-line Reporting Availability

The Dependent Eligibility Audit (DEA) software package used by HDM/PCG has robust report management capabilities. The reports summarize information on a real-time basis and can be produced at the press of button. We will provide PEIA management with 24/7 access to these reports via the web to allow real-time status of our progress. Web site availability will exceed 99% for the life of this project. **Failure to maintain on-line availability at this level will result in forfeiture of one percent of our fees.**

A partial list of the key reports with descriptions is included below:

Audit Phase	Report Title	Description
Total Audit	Unreturned Grace Period and Verification Packages	A combined listing of all policyholders who did not respond by submitting any requested documentation, in either/both the Grace Period or Verification phases.
Total Audit	Dependents disenrolled	The total list of identified ineligible dependents identified
Total Audit	Red Flag Report	A listing of dependents with special issues to be privately reviewed by the client.
Grace Period Phase	Dependents Disenrolled List – Grace Period Phase	A report listing all dependents voluntarily disenrolled by the policyholder during the Grace Period.
Verification Phase	Verification Phase Open Action Items	All open action items defined during the Verification Phase of the review that are still open.
Verification Phase	Review Team Decisions –All Decisions	A review of all decisions (Eligible, Ineligible, Red-flag) made by the Review Team.
Appeal Phase	Overview of Appeal Phase	Overview report of all Appeal actions and decisions.
Appeal Phase	Appeal Team Open Action Items	A report of all action items created by the Appeal Team that are still open.
Total Audit	Productivity Measurement – Scanning History	A productivity report on the time required to process in-bound mail, scan it and import it in the DEV software.

The software package includes other reports and is flexible enough that reports could be customized, if necessary. The HDM/PCG team is committed to an effective collaboration with our clients and will produce management reports on a regular schedule if PEIA wishes.

Call Center Timeliness

As stated in our proposal, call center service will be provided by Public Consulting Group staff. The PCG Bangor Maine call center will service PEIA dependent eligibility inquiries. PCG has managed and operated this call center for over 10 years. The call center currently serves over 171,000 Maine Care Managed Care eligibles, providing services to providers as well as

members. During that time call center staff has proven their ability to exceed customer expectations. Currently there are 24 call center FTEs answering an average of 1,200 calls a day from MaineCare members and providers. Our call center statistics for the first 3 months of 2009 are as follows:

Metric	January	February	March
Number of Business Days	20	19	21
Total Calls Received	26,299	23,747	26,921
Total Calls Answered	24,75	22,76	25,60
Percentage of Calls	100%	100%	100%
Average Daily Calls	1,289	1,230	1,282
Average Handle Time	4.63	4.71	4.49

Percentage of Calls			
	5.50	3.60	4.35

We expect the call volume for the dependent eligibility audit to be considerably less and, consequently, are confident of our ability to provide equally superior service to PEIA and its members. In this regard, we will guarantee telephone accessibility of 95% of calls answered within 30 seconds. **We will put at risk one percent of our fee for failure to meet this standard.**

We will also manage our call center's abandoned call performance. We will put at risk one percent of our fee for failure to maintain abandonment rate of no more than 3% of all calls.

Document Processing

Since 2004, PCG has provided consumer-direct fiscal/employer agent services to a statewide Medicaid program. Under this program recipients send an average of 20,000 fax images weekly. The images are sent from recipients nationwide via a standard fax machine. Each image is stored as a either a 'pdf' or 'tif' file on a large server. Staff members use an OCR reader software application to pull down the images and verify the data. The software bundles many images together into a batch file. Numbers and other information are verified on the screen and the indexed and validated data is downloaded by the software application into a payment processing database. Images are stored on a secure server. If awarded the contract with West Virginia, we would seek to leverage this technology to address process the high volume of incoming mail we expect this engagement to generate.

We will establish a performance standard where 95% of all documents are indexed and stored electronically within 48 hours of receipt. Failure to meet this standard will result in the forfeiture of two percent of our fees.

Indexing and Retention of Records by PEIA

Our dependent eligibility audit software package features a thorough closeout process for electronic data. At the close of the audit, the HDM/PCG team will be able to hand over electronic files that contain all of the documentation submitted by subscribers to PEIA management. We will follow the instructions of PEIA with regard to our disposition of the data. If you would like us to purge the information from our systems, we will do so. On the other hand, if PEIA wishes us to maintain electronic copies for future reference, we will comply with that wish as well. PCG, who will have custody of both hardcopy and electronic documentation, has a rigorous document maintenance and storage plan and has 20 years of experience in handling sensitive personal (and personnel) information.

Audit Accuracy

With the documentation provided by employees and dependents as the basis for each determination, we will commit to an audit accuracy of at least 98%.

For purposes of this guarantee, "accuracy" means the correct reporting of a member's status to PEIA, i.e. that a member is either eligible or not eligible based on the documents presented by the employee. Any member whose status is incorrectly reported to PEIA (and presumably later reversed) will count as an error toward this calculation.

Return on Investment

As we stated in our proposal, we believe that the PEIA likely had a number of firms willing to guarantee their return as measured by establishing some percentage of the dependents as ineligible. We believe that the number of ineligible is established, no matter which firm conducts the audit, and that every firm's result, expressed by the number of ineligibles discovered, will be the same. The reason is that the responsibility for proving a dependent's eligibility is the employee's. Valid documentation will not vary from audit firm to audit firm.

We are willing to guarantee that we will uncover at least enough ineligible dependents to neutralize the cost of the audit. To determine whether we achieve this goal we will use $2,200.00 as the cost of the average dependent. With an approximate cost of $601,552 for the dependent eligibility audit (209,600 members times $2.87) we need to report approximately 273 currently enrolled dependents as ineligible ($601,552 divided by $2,200.00 equals 273.) **For every dependent short of this target we will forfeit $3,500.00.**

Service Performance	Guarantee	Guarantee Method	Fee at Risk	Time Frame
Online Reporting Availability	24/7 Access to Online Reporting >99% over life of audit	Quarterly measurement	1% of fees	Conclusion of audit
Call Center Timeliness	Average speed of answer at 30 seconds or less	Quarterly Summary	1% of fees	Conclusion of audit
	3% or less Abandonment Rate	Quarterly Summary Abandonment Percentage Report	1% of fees	Conclusion of audit
Document Processing	95% of all documents are indexed and stored electronically within 48 hours of receipt	Quarterly	2% of fees	Conclusion of audit
Audit Accuracy	98% accuracy in	Conclusion of	5% of fees	Conclusion

	reporting of member status to PEIA	Audit		of audit
Return on Investment	Number of Ineligible Dependents identified will equal cost of audit	Conclusion of Audit	$3500 per dependent	Conclusion of audit

Exhibit 4

Invoicing and Payment Schedule

As described throughout this document, PEIA has engaged HDM to perform an enrollment reconciliation analysis (ERA) comparing its current enrollment in various employee benefit plans to three months payroll records for approximately 600 non-state and 200 state agencies. In addition, PEIA requires that HDM verify the eligibility of all dependents of employees in these same agencies through a dependent eligibility verification process (DEV). The ERA requires the comparison of approximately 107,000 policyholders to the PEIA eligibility files, while the verification of eligibility of dependents currently showing active on the PEIA files will require contact with, and receipt of documentation from, an estimated 209,600 dependent units. We estimate the project to end by February or March 2010. HDM will execute the project in four waves, the first of which begins at or about August 1, 2009 and the last of which will commence late fourth quarter 2009.

Given the estimated time to completion, significant front-end set-up work affecting all four waves, variability in scope among the waves, and a commitment from HDM to perform the work on both a PEPM (the ERA) and PMPM (the DEV) HDM and PEIA agree to the following outline as to the invoicing and payment of fees. This approach recognizes the ongoing work (and costs incurred, thereby) performed by HDM, while satisfying the State of West Virginia's requirement that vendor reimbursement should follow completion of work.

The cost of the project to PEIA is $1.10 per policyholder (ERA) times an estimated 107,000 policyholders, and $2.87 per member (DEV) times an estimated 209,600 members. Both PEIA and HDM recognize that since these figures represent a one-time cost per member and per policyholder, spreading reimbursement over the course of the project means that the initial payments need to occur as flat payments, with the final payment (based on the actual policyholder/member counts times $1.10 and $2.87 respectively) netted against the earlier payments.

Since HDM and its sub-contractor, PCG will have completed considerable work to establish the framework for these projects over the first ten weeks (beginning June 15, 2009). This baseline work is critical to the project and serves as the underpinning of all four waves.

This agreement recognizes that HDM and PCG have incurred direct expenses in support of the project beginning June 15, 2009. Incurred expenses include direct salaries, rent, travel, meetings with PEIA, consulting with PEIA staff as to approach, a Benefit Coordinator webinar, expanded licensing costs, and one on-site training session for upwards of 150 Benefits Coordinators.

PEIA and HDM therefore agree that the invoicing and reimbursement occur in five phases at 20% of the total estimated project cost, with 20% of each phase (4 points of each phase's 20 points) withheld until project completion and reconciliation of the project cost. The five phases and associated work steps are:

Phase 1 - Project Set-Up Work and Expenses Incurred To Date (mostly non-recurring work):

- Design of project scope, approach, and timetable, including approval of all by PEIA,
- Design and creation of the record layout for transmission of data,
- Establishment of secure FTP site and security protocols for transmission of payroll data to HDM,
- Testing FTP site and receipt of data,
- Purchase of additional system licenses to maintain capacity several multiples of expected volume of paper transactions,
- Creation of dedicated telephone service center and attendant rental costs,
- PEIA specific training of dedicated phone center service representatives,
- Purchase of dedicated toll-free line to service center,
- Rental of dedicated mail-box in Morgantown, West Virginia,
- Establishing project specifications for mailing partner to automate a significant portion of the mailings,
- Consulting with PEIA staff on "grace period,"
- Consulting with PEIA staff regarding appeal process and other critical decision points,
- Hiring of dedicated project manager,
- Management of weekly meetings with PEIA staff,
- Design and writing of communications material customized to PEIA needs (all of which apply to the four waves):
  1. Initial letter to Benefits Coordinators in the pilot wave
  2. Letter to employees
  3. Grace period affidavit
  4. Proper documentation instructions
  5. General instructions
- Preparation of FAQ documents for PEIA web site,
- Receipt and testing of payroll files from pilot agencies,
- Education of Benefit Coordinators along with associated expense:
  1. August 11 webinar for pilot agencies
  2. August 21 on-site in Flatwoods, WV
- Design of reports for PEIA staff

Phase 2 – Execution of Pilot Wave

This phase will begin on or about August 1 with the Enrollment Reconciliation Analysis for the agencies selected for this pilot. The Phase 1 ERA will close September 7, while its DEV portion will commence about fifteen days thereafter.

Invoicing for Phases 1 and 2 will occur following the first wave DEV mailing.

Phase 3 – Wave Two of both Projects

This wave incorporates the remaining non-state agencies (approximately 570) and will commence somewhere in September with the ERA portion and October for the DEV. Invoicing for Phase 3 would take place following the DEV mailing in October.

Phase 4 – Wave Three of both Projects

This wave incorporates approximately one-half of the State agencies and employees. The ERA mailing would occur in October with the initial DEV letter following one month later. Phase 4 invoicing would occur following the first DEV mailing of this wave.

Phase 5 – Wave Four of both Projects

This final wave includes the remaining State agencies and their employees. The ERA mailing will occur in November with the initial DEV letter scheduled for mailing in December. Phase 5 invoicing would take place following the mailing of the first DEV letter of this wave.

Reconciliation - Final reconciliation of the project cost, and settlement of the dollars withheld in each phase, will occur upon the completion of Wave Four activity and completion of the overall project.

Exhibit 5

Proposal to the West Virginia Public Employees Insurance Agency

Enrollment Reconciliation Analysis

Dependent Eligibility Audit

Tobacco Free Premium Differential Audit

March 13, 2009

Presented by:
James Herrington
Chief Marketing Officer
Healthcare Data Management, Inc.

March 13, 2009

Ms. T. C. Cyrus, RN, CMCN
Manager, Healthcare Compliance & Quality Assurance
West Virginia Public Employees Insurance Agency
1900 Kanawha Boulevard, East
Charleston, WV 25305-0710

Dear Ms. Cyrus,

Please accept this proposal from the combined team of Healthcare Data Management and Public Consulting Group. This proposal marries the strong audit and audit management capabilities of Healthcare Data Management (HDM) with the exceptional ability of Public Consulting Group (PCG) to service the needs of individuals employed in the public sector. Indeed, PCG has considerable experience in serving state governments and their members in a considerable number of locations across the country. Moreover, PCG's technical platform is geared to the requirements of state level government, including the State of West Virginia.

Why combine HDM and PCG? Well, we think there are several reasons. First we are both known quantities to the State and to PEIA staff. We understand your culture, needs and challenges. Combined, we have the scale to ensure that your audits are performed on time along with the value and results you seek. And, because we each have ongoing relationships with the State, we each have employees who will be there throughout the audits and still in contact with you when the audit is complete.

HDM is the nation's leading health care auditing firm, and, in addition to serving the PEIA, serves the states of Maryland, North Carolina, Massachusetts, the Center for Medicare and Medicaid Services and others. Audits of the scope articulated in your RFQ are not new to HDM. In addition to the public entities already mentioned, we serve private sector clients such as Ford Motor Company, AT&T, Raytheon, and many others with audit requirements of significant size.

In its 20 year plus history, PCG has risen to one of the premier consulting/service companies serving the public sector at every level, demonstrating time and time again its focus on results for its customers.

In our proposal we detail how we effectively our systems can interface with the PEIA, TPAs, and State agencies and data warehouse systems. We will accept data in the formats as provided by PEIA and its agencies. In the case of both HDM and PCG, all systems are either proprietary or under our own software licenses.

While the idea of dependent eligibility audits is just beginning to take root in the marketplace, both HDM and PCG are quite experienced in assessing a member's eligibility for benefits. This experience comes about from having performed dependent eligibility audits, assessing eligibility as a matter of course in any audit, and, on occasion, performing the kind of match and compare tasks required as part of the enrollment reconciliation audit.

The most important element of the dependent eligibility audit is how effective the audit firm communicates with the plan sponsor (PEIA) and, as important, its members. We know from

experience that this process can be intimidating to employees and dependents, so we take great care to demonstrate our ability to effectively produce value while at the same time demonstrating sensitivity to your members. We believe that both HDM and PCG have already proven our respective ability to communicate effectively and with timeliness to PEIA staff and members.

We are grateful for the opportunity to show our capabilities and stand ready to answer your questions about our proposal.

Best Regards,

James Herrington
Chief Marketing Officer

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SECTION I: CORPORATE OVERVIEW

Healthcare Data Management and Public Consulting Group have teamed on this project to bring innovative ideas and a proven approach to this project for the West Virginia Public Employees Insurance Agency (PEIA.)

Healthcare Data Management, Inc. (HDM) and Public Consulting Group, Inc. (HDM) will provide the PEIA with the staff, understanding, and resources to conduct a thorough and successful Dependent Eligibility Audit (DEA) audit. We believe that both PCG and HDM's successful track records of providing audit-related services to public sector clients and PCG's vast experience in managing, staffing, and operating call centers in conjunction with HDM's established DEA audit processes and procedures make our partnership a strong candidate to deliver great value for the PEIA through the DEA audit. Moreover, both HDM and PCG have both previously demonstrated the ability to meet the rigorous demands of several State agencies, including the PEIA.

We believe that HDM and PCG have synergistic capabilities that will come together to offer great benefit on this engagement. HDM brings many years of public sector focus and a history of success in healthcare related engagements. PCG's 10 years of experience in managing, staffing, and operating call centers will enable us to appropriately train those who will be the public face of our partnership. Understanding the sensitive nature of this audit, HDM and PCG will match our training program to the audience and the situation. HDM, having conducted several DEA audits in the past, will leverage that experience to create an effective communication plan that, like our call center, will be cognizant of employee relations and other dynamics that these audits sometimes create. We are excited about the prospect of working together on this project and have already been in discussions about structuring the relationship in a way that will maximize the benefit to the PEIA.

Overview of Healthcare Data Management (HDM)

HDM brings to this engagement proven experience in dependent eligibility audits working extensively for employee benefit plans since 1992 for companies such as AT&T and public sector clients such as the West Virginia Public Employee Insurance Agency.

Founded in 1992, HDM is a privately held company and is the leading independent source for self-insured plan sponsors in both the private and public sectors to maximize the value and accountability of health benefit programs. HDM firmly believes that the success of our organization is achieved by understanding the needs of our customers, providing a quality service and maintaining the highest standards of professional conduct. We are committed to delivering an unparalleled customer experience. Each HDM employee is committed to meeting customer needs and expectations and achieving a high quality of service.

Since its inception, HDM has developed proprietary services and technology to evaluate both historical and current health plan operations to give the assurances that our customers need, while generating cost savings. HDM offers a range of services to assist both self-insured and fully funded employers manage their medical and dental plans, including:

- ***Dependent Eligibility Auditing*** – HDM has developed and refined a dependent eligibility auditing service that is efficient and at the same time sensitive to employee relations and other issues that often arise during these audits. This service and the processes that make it up have proven to be important tools for effectively identifying

and removing ineligible dependents from employer-sponsored medical and/or dental plans.

- ***BenefitsAudit*** – HDM has provided many retrospective audits of health/dental plan administrators and pharmacy benefit managers for both private and public sector employers. HDM offers an extensive review that assures compliance with government and other auditing standards while identifying performance issues that often result in recovery for past overcharges. As part of this audit, HDM provides its customers with recommendations to improve the administration of the plans prospectively.
- ***BenefitsWatch*** – With its BenefitsWatch tool, HDM has established a service that allows employers to improve the compliance of its plans. It is an ongoing solution for financial surveillance, health expense management and performance monitoring. We analyze claims data for each plan and perform ongoing analysis, monitoring and reporting. We provide robust reporting and a dedicated expert analyst to generate actionable information in managing healthcare costs and risk. Our service impacts our clients' ability to make better health benefit decisions and vendor management assessments.
- ***Provider Bill Auditing*** – HDM's provider bill auditing process is an efficient and effective method to reduce large dollar inpatient and outpatient claims exposure.

HDM's management team and its staff have a deep understanding of health plan administration practices across both the private and public sectors, including, of course, those of the PEIA. HDM has proven its ability to implement large scale audit/recovery programs (e.g. Ford Motor Company, the Medicare Part D Program for CMS, and State of Maryland), and HDM has proven its ability to produce high quality audit reports that are delivered on time and offer clear benefits to its clients. HDM has years of experience performing audits and has continually evolved processes to meet client/partner needs and is flexible to meet the changing environment.

HDM has conducted DEA audits for a diverse group of clients over the past two years. The following are examples of recent successful projects:

MeadWestvaco (MWV) – Virginia-based MWV is a global leader in packaging solutions for the personal and beauty care, healthcare and pharmaceuticals, food and beverage, dispensing solutions, home and garden and media industries. A seven billion dollar corporation, the company employs over 23,000 people and has a presence in over 25 states. MWV engaged Healthcare Data Management to perform an audit of dependent eligibility for one of their major divisions. The audit revealed that over 10% of the actively enrolled dependents were indeed ineligible. At a conservative estimated value of $2,500 in claims costs for the average dependent, the company was able to achieve a significant return on investment through its work with HDM.

Wide Open West (WOW) - Although smaller in size than MWV, Wide Open West, a cable television and internet service provider serving urban areas in the central United States, asked HDM to evaluate the status of their enrolled dependents. Following a similar process as with MWV, HDM determined that between as few as 13% and as many as 18% of the enrolled dependents were no longer eligible for coverage under their plan. The difference between these two figures is the number of people that have appealed the possibility of being removed from the plan. As with MWV, the savings from removing ineligible dependents was several times the cost of performing the audit.

HDM's headquarters are located in King of Prussia, PA, and we have offices in Boston, MA, Wilmington, NC, Dallas, TX, and Chicago, IL. We currently employ 35 full time staff and utilize additional contracted audit professionals as necessary.

Overview of Public Consulting Group (PCG)

PCG brings proven call center and technology project successes from both within West Virginia and nationally. If chosen to provide this service, PCG will dedicate a team of experienced professionals throughout the country to support this project.

PCG is a management consulting firm that specializes in serving public and private health and human services agencies and providers. PCG has extensive experience in all facets of the healthcare delivery system including both payers and providers. PCG's work for payers focuses on health plan expense management including eligibility determinations, cost shifting strategies and claims and member audit protocols. Likewise, PCG's work for the provider market includes hospital operations, third-party reimbursement and audit and compliance work. Since its inception, PCG has assisted state agencies and healthcare providers with a variety of financial and accounting activities.

Unlike other firms, PCG dedicates itself to the unique and challenging environment of the public sector. PCG has developed a diverse array of expertise and often calls upon the work completed in other states, cities and counties to strengthen both our project understanding and the development of our final deliverables. In addition to PCG's breadth of experience, its staff is technology focused, adept and equipped with the latest information technology resources and experience, allowing us to effectively collect, analyze, and manage large databases in order to complete analytics and automate operations.

PCG has extensive audit and review experience working with state health and human services agencies in 45 states. PCG's experience has helped us develop standard audit and compliance-related processes. PCG currently conducts facility audit and review services for state clients including North Carolina, Wisconsin, Florida, Louisiana, West Virginia, and Massachusetts. Specifically, PCG has audited Skilled Nursing Facilities (SNF's) in Massachusetts, Intensive Care/Mental Retardation Facilities (ICF/MR's) in Illinois, Critical Access Hospitals (CAH's) in West Virginia, State-Owned Institutions for Mental Diseases (IMD's) in North Carolina, Massachusetts, Florida, Missouri, Louisiana, Alaska, Illinois, and West Virginia, and hospitals in virtually every state in the country. PCG's in-depth understanding of audit work performed on behalf of public sector clients as well as its long standing professional contacts within the audit community across the country and local experience working for more than 15 years for various state and local governments, including several projects with the State of West Virginia, uniquely positions PCG to partner with HDM to respond to this RFP.

PCG has enjoyed a long and successful history working with the State of West Virginia Department of Health and Human Resources (DHHR) on a variety of revenue enhancement projects. Since 1995, PCG has been providing third party liability (TPL) services to recover Medicaid funds from previously paid claims from other insurers. PCG has recovered more than $60 million and provided an additional $200 million in cost savings through verified insurance policies and a Medicare repricing initiative.

In addition to the success of PCG's TPL initiative, the firm was awarded a revenue maximization contract in 2002 that has resulted in the state drawing down significantly higher federal funding. In all, PCG has assessed more than 50 opportunities spanning each of the five health and human services agencies under the DHHR. PCG has recovered more than $100 million through the successful implementation of both Medicaid and Title IV-E project initiatives.

SECTION II: PROJECT BACKGROUND, UNDERSTANDING, & GOALS

The HDM/PCG Team have a thorough understanding of the project goals and objectives and a proven approach to providing the PEIA with the most efficient, effective and responsive team to perform this work. By combining the strengths of both firms we will exceed your expectations as to successfully completing the three major audits:

- Conducting an Enrollment Reconciliation Analysis by comparing the payroll and eligibility records of all plan participants thereby ascertaining each individual's eligibility while verifying that each participating agency complies with the PEIA's criteria for participation, and,
- Performing a Dependent Eligibility Audit to determine the eligibility for 100% of PEIA policyholders, retirees, and dependents, and,
- A comparison of claims data to eligibility to determine whether members with evidence of tobacco abuse are receiving discounted tobacco-free premium.

The purpose of this project is to provide all three audit services for the PEIA. The project has two primary objectives: prospective cost savings; and improved compliance. A third objective is the ability to improve the internal control policies and procedures so that ineligible dependents are prevented from becoming enrolled or are disenrolled promptly upon the occurrence of any event that renders them ineligible.

The HDM/PCG team offers the PEIA a unique understanding of the issues surrounding this engagement. We understand the objective is to identify ineligible dependents and remove them from the PEIA's fiscal responsibility. From a human aspect, however, the PEIA will want to ensure these ineligible dependents find coverage outside of the PEIA's health plan. As such, the HDM/PCG Team will use our comprehensive understanding of other health programs such SCHIP, Medicaid and the private health insurance market to direct those individuals in need of health coverage. Our goal is to ensure that if someone is disenrolled from the PEIA's health plan, we assist these individuals with all of the possible options available and make every effort to facilitate enrollment into another plan. ***No other vendor bidding on this job will have more relevant knowledge of the available public and private insurance market in West Virginia than the HDM/PCG Team.***

We also want to ensure that participating agencies, both state and non-state are compliant with the eligibility requirements established for participation in the PEIA benefits program.

Additionally, through the use of HDM's data warehouse and other auditing tools, we will identify those individuals who currently receive discounted tobacco-free premiums by comparing their individual claims to medical treatments and services traditionally associated with tobacco use. This information will be shared in a HIPAA compliant format with state officials for determination as to whether the individual is eligible for tobacco-free discounted premiums.

The project goals will be achieved through the identification of ineligible (or inadequately documented) dependents currently enrolled on the PEIA's medical and dental insurance plans. Per the RFP, the HDM/PCG team will present a final report that will contain the names of those individuals to PEIA officials. All discretion about how to address the individuals from that point will rest squarely with the PEIA. Based on industry norms, it can be expected that at least 10% of all dependents will be determined ineligible for coverage under the PEIA's plans.

Keys to the project's success include:

- Working collaboratively with PEIA officials to craft a communication plan that effectively conveys the reasons for and the goals of the audits;
- Accurately auditing member-supplied documentation with respect to dependent eligibility;
- Accurately and quickly processing large volumes of documents. HDM estimates this project entails the receipt, processing, scanning, and uploading of several tens of thousands of documents;
- Providing the PEIA information in a "usable" format. Due to the volume of documentation generated from this project, electronic and hard copy file maintenance is of paramount importance;
- Providing appropriate and accurate responses to PEIA member inquiries. HDM expects significant call volume over the life of this project. Accurate information must be provided to members to minimize the number of calls. Further, all member phone calls must be answered in a professional and courteous manner; and
- Maintaining necessary staff levels with appropriate training and skill sets to complete all aspects of the DEA project. This project requires staff with multi-disciplinary expertise including client care operations, systems, project management, quality control, human resources, finance, and technology.

In compliance with the Request for Proposal, HDM/PCG recognizes that the following milestones/deliverables must be met:

- Implementation of an amnesty period prior to the review. HDM/PCG will work with PEIA officials to establish an amnesty period with appropriate timeframes and parameters;
- Development of a letter-based employee communication program with content agreed to by the PEIA, requiring the employees to submit documentation;
- Receipt and housing of documentation evidencing compliance with the requirements for dependent eligibility;
- Resolution of employee and dependent questions throughout the engagement utilizing call center and secure web-based solutions;
- Retention of documentation in digital form throughout the audit engagement and hardcopy form for three years thereafter. We will retain hardcopy documentation for three years following the end of the project;
- Provision of digital file(s) with imaged documentation to the PEIA; and
- Provision of secure data storage or disposal.
- Clear communication with each of the non-state agencies with respect to the enrollment reconciliation analysis, with particular emphasis on the requirements and responsibilities of the agency.

We believe that the PEIA will encounter a number of firms willing to guarantee their return as measured by establishing some percentage of the dependents as ineligible. We believe that the number of ineligible dependents is established and that the proper approach is simply to uncover the information necessary to document this. Any potential vendor is dependent upon the employee producing the appropriate documentation to establish eligibility. That documentation will not vary from firm to firm. Consequently, the value added by the vendor is the clear communication of the audit and its goals, the sensitive approach to employees and their dependents, and fair analysis of the documents submitted.

The HDM/PCG Team has prepared a work plan with this understanding of the project and its goals as the backdrop. The work plan is attached to this proposal.

SECTION III: DATA MANAGEMENT/ELIGIBILITY TECHNOLOGY PLATFORM

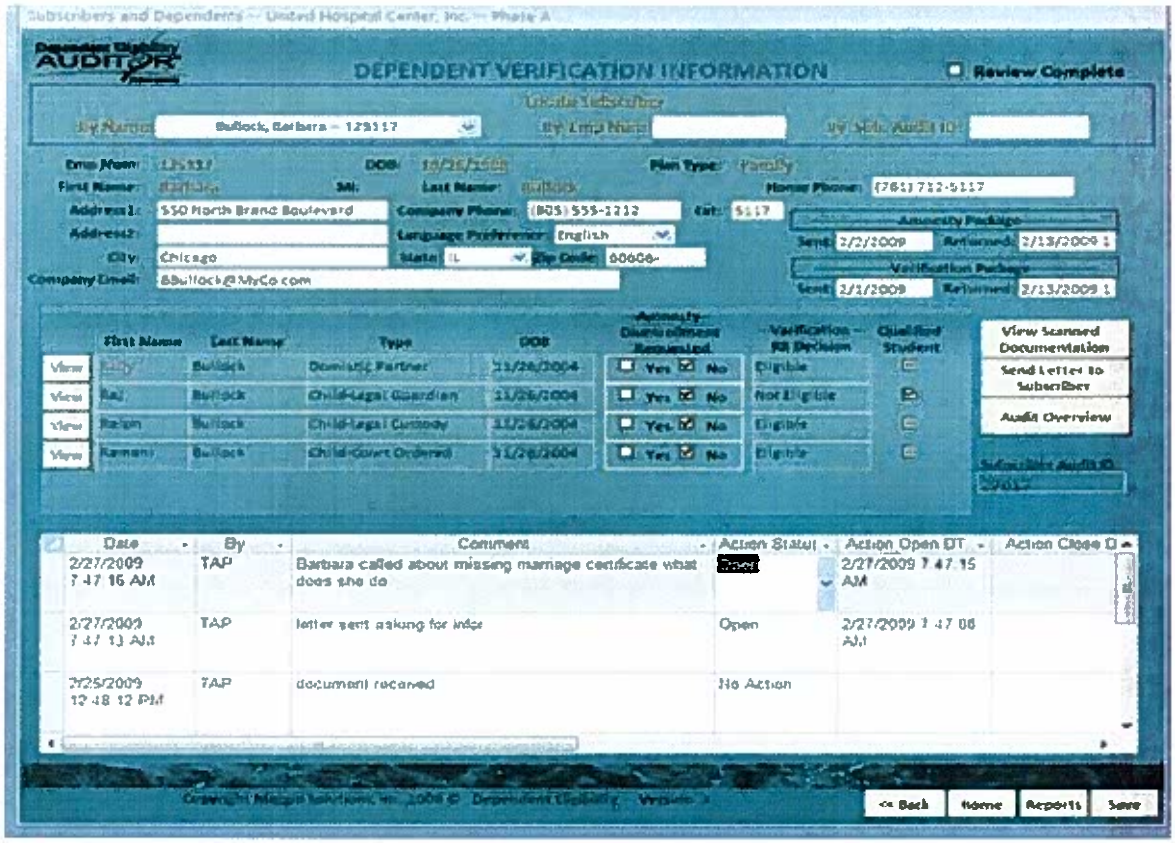
The HDM/PCG team has specifically incorporated a proven technology platform into the Dependent Eligibility Audit process to ensure accurate flow of data and efficient management reporting to better serve PEIA.

The Dependent Eligibility Auditor™ is a client/server application residing as a single instance on a secure server protected by the firewall of PCG's Local Area Network. The back-end database is SQL-2005. The application and all transactional / scanned image files run on a server within a physically secure location. The client's subscriber/dependent data import is accomplished by a simple export of the required data from the client's human resources database system in an Excel format and directly imported into the Dependent Eligibility Auditor™. The application has been tested to 100,000 subscriber/dependent records per license. While we anticipate this audit including more than 100,000 records, it is simple and cost-effective to obtain additional licenses as necessary. Data security is accomplished within the application not only by standard ID/PW but also by "Roles" which limit reviewer's access to specific data on a need to know basis. As an example, the inbound data scanner only has access to the "scanning input screen" and does not have access to any other information. The application also tags every entry with the ID of the person making that change.

The eligibility reviewers will access the application through hard-wired LAN connected desktops without visual access by pedestrians. Each reviewer will have a dual screen capability for the application and entering comments, actions, or decisions and for the displaying of the scanned documents. Each reviewer will also have a dedicated printer for printing custom letters requesting additional information or clarification. All letters authored are also stored in the database and date/time-stamped and tagged by the reviewer who wrote each letter. All systems will time-out automatically if the reviewer leaves the office area and will require a complete login to resume the session upon return. None of the actual data will be stored on the reviewer's desktop and will only reside on the secure server within the server room.

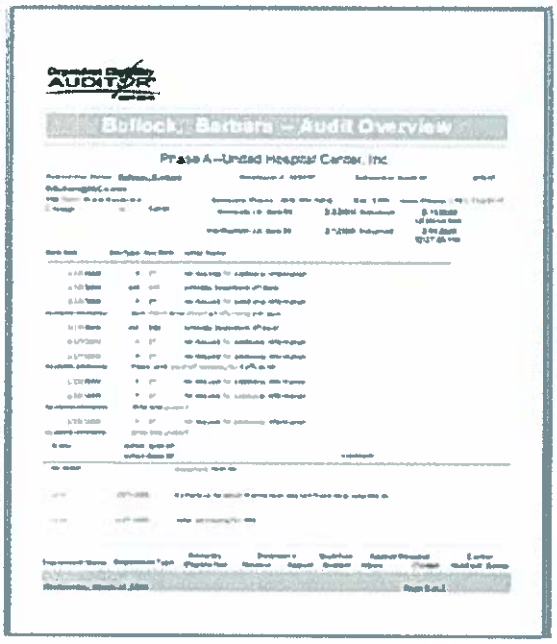
The Dependent Eligibility Auditor™ application has separate screens to support the Help Desk, Review Board and Appeal Board processes. As an example, the Review Board screen, shown below, provides immediate access to all subscriber and dependent information, decisions, action items, scanned documents, and decision status. Access to a similar screen for each dependent is immediately available by selecting the "view" button from the dependent list.

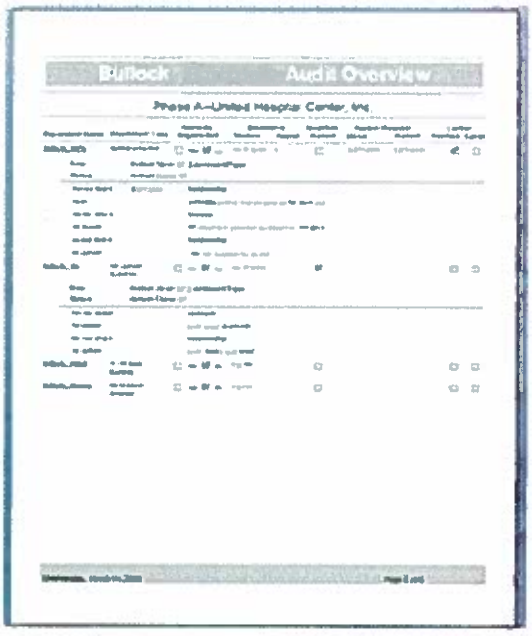
Sample Review Board Screen



Multiple reviewers can work simultaneously on a single audit through the Dependent Eligibility Auditor™ automated "To-Do-List". This single automated listing is available to all reviewers and as each subscriber is selected and processed, it is removed from the list until none remain. The application has an automated "To-Do-List" for" a variety of topics such as "Un-reviewed New Scanned Documents", " Open Action Items", "Un-returned Amnesty Packages", etc.

The status of every subscriber and their dependents is instantly available with an on-demand report as shown below. These are useful for managing the details of the total audit.





The system is also capable of automated mass printing of thousands of custom letters and their associated inbound and outbound envelopes. In one command, thousands of letters can be created such as a "Mid-Amnesty Reminder" letter. The system will read the database and locate those subscribers who have not yet returned their Amnesty packages and create a letter to each for mass mailing. Other automated topics include decision letters on ineligibility and open action item letters where the subscribers need to provide requested information. HDM maintains a variety of letters that can be written in addition to new letter templates as required. All letters can be printed automatically in up to nine different languages as requested by the subscriber.

The system is also capable of dividing a single large audit into individual groups so they can be divided by region, district, employee category, or any other categories the client wishes. A variety of "On-Demand" reports can also be generated to monitor the status of the audit. Reports such as a listing of those found to be ineligible to date, how many open action items remain open from the Help Desk, How many Red-Flagged Issues are outstanding and a number of other reports. Also a complete report on any individual subscriber and their claimed dependent(s) can be generated at any time.

At the end of an audit, there is the capability to archive the total audit and deliver to the client a complete digital PDF file of everything recorded during the audit for future reference. The final step of the archive process is that all data is purged from the system (if requested) to minimize the possibility of identity theft.

SECTION IV: COMMUNICATION METHODOLOGY

The HDM/PCG Team takes great pride in our commitment to providing outstanding customer service with precise communication, accurate reporting and to better serve our clients.

HDM has been providing employee benefit plan audit services since 1992 and has deep experience in preparing our clients for any questions or concerns expressed by employees about audit activities. The HDM/PCG team will work closely with PEIA staff to develop all communications prior to being sent to employees. Our aim is to understand the "atmosphere" surrounding the PEIA's efforts to assist both the employees impacted and PEIA staff in achieving a positive outcome as a result of the audit. We will develop a set of FAQs for the PEIA so that your staff is prepared to answer any in-bound employee questions or concerns. We will provide a designated call center for employees to contact with any questions they may have. Our goal is to make the outbound communication process so clear and effective that most employees will have no need to call us for additional instructions or clarification.

We understand that a dependent eligibility audit can be a sensitive topic with internal "political" consequences and repercussions. So, while our communication plan will depend, in large part, on the wishes and needs of each individual client, our general communication plan is outlined below.

The first step in the audit process is the transfer of the employees' and dependents' eligibility files that contain detailed enrollment records of all employees who currently have dependents enrolled on the PEIA's health and dental plans. The data must include specific enrollment and demographic information pertaining to all enrolled dependents and must also contain any changes, terminations, or updates that may have occurred during any amnesty period. HDM/PCG will provide a data specifications document outlining these requirements.

Please note that in this section, we present our general communication plan. Our specific audit plan for this engagement is presented in Section VI: Project Plan & Timeline.

Step 1: Implement Amnesty Procedures

We will incorporate an amnesty period which can be a very important tool for effectively identifying and removing ineligible dependents from an employer's health plan. An amnesty period, as part of a dependent eligibility audit, involves a time period (typically 30 days) during which employees are requested to self-report any dependents that are enrolled in their employer's medical plan who are not meeting the plan's eligibility requirements. This self-reporting of ineligible dependents typically enables employees to self-report their ineligible dependents without any financial consequences. Our audit team will send letters to all employees with dependents outlining the amnesty program and the requirements for dependents to be eligible. The letter will list all current dependents associated with the employee, the process for removing ineligible dependents, and a toll-free phone number and web site that may be accessed for additional information.

Step 2: Initiate Audit Protocol

Upon completion of the amnesty period and collection of necessary data documenting those dependents who are now disenrolled as a result, the team will initiate the actual audit process using the following workflow process:

Initial Letter	We send an audit notification letter and form to the home addresses (provided to us in the PEIA's eligibility data) of each employee with a dependent. Any letters returned as undeliverable will be re-directed to the PEIA for corrected addresses.
Employee Responses	Employee responses and all related documents will be sent to a PO Box designated by HDM with the document request letters. We then monitor responses and review all submitted documents in order to identify those not meeting the plan's requirements and to confirm dependents that are eligible.
Non-Respondents	Two follow-up letters will be sent to employees not responding by the deadline. The deadline to respond (typically 30 days) will be included in the document request letter. Actions to be taken relative to those who fail to respond before the deadline will be clearly defined. The PEIA's staff will determine if non-respondents will be subject to loss of coverage, and exactly when this will occur.
COBRA	Some dependents may be eligible for COBRA depending on when they become ineligible to remain on the PEIA's medical or dental plans. Our team will educate those individuals as to their COBRA options.
Telephone Calls	Undoubtedly, a potential loss of coverage for dependents will generate some questions and telephone calls. Any such questions and telephone calls can be directed to our designated call center which will have trained staff dedicated to answering specific questions. Our call center operations and training information are included in a separate section of this proposal.
FAQ	We will provide answers to frequently asked questions to the PEIA for its staff as well as a list of frequently asked questions and answers which will go to employees. In addition, the audit letter will contain specific eligibility requirements for dependents and a list of acceptable documents. We will work closely with PEIA staff overseeing this project and provide the necessary support for your communications with employees throughout this engagement.
Status Letter	A letter will be sent to each employee with dependents notifying them of the audit status; either that the proper information was received and dependents are eligible, or that information was not received and/or incomplete and that their dependents' coverage may be terminated.

Step 3: Perform Impact Analysis

A report will be sent to PEIA officials that lists employees with ineligible dependents. The PEIA may then complete the removal of ineligible dependents from their Eligibility Management system should they choose to do so.

As part of the final report, our audit team will also provide recommendations for the PEIA on improving its internal processes so that ineligible dependents are identified more quickly and efficiently. Although a member or dependent's eligibility is a snapshot in time, there are processes, procedures and communication protocol that may be put in place among the PEIA, its employees and the administrator of the plans. It is important that eligibility audit becomes an ongoing and continuous process and is not approached as a "clean up" function that must be performed every couple of years. The cost avoidance ramifications are too great for the PEIA not to institutionalize improved operational procedures.

Step 4: Initiate Recovery/Collections

A majority of employers do not pursue collections from employees due to the adverse impact on employee relations. If the PEIA wishes to pursue collections from employees who have been found to have ineligible dependents covered on the PEIA's medical and/or dental plans, there are two options: (1) The PEIA may deduct money from employees' pay or (2) The PEIA may choose to hire collections firm to recover the money. For most employers the benefit of future savings from having dependents removed is sufficient return on investment for the project. HDM/PCG can assist in the selection of or recommend a third-party collection partner if desired.

SECTION V: CALL CENTER TECHNOLOGY & OPERATIONS

PCG has extensive experience operating call centers and other operations units throughout the country for public agencies, and we offer the PEIA a trusted partner for this engagement.

With extensive experience in managing and operating call centers in several states across the country for more than 10 years, PCG can immediately establish a designated call center to service the DEA project. Since 1998, PCG has staffed and operated call centers on behalf of public clients on a variety of different projects. The organizational and institutional knowledge and understanding that we bring to bear will translate well into this new environment.

The most effective way to demonstrate our team's experience in call center operations is to outline actual project work performed and the significant value realized by our clients as a result of these efforts as evidenced by the following project descriptions of our previous and current efforts:

State of North Carolina, Health Benefits Advisory Services

From 1996 through 2007, PCG assisted North Carolina, Division of Medical Assistance (DMA), with the development, implementation and expansion of the Health Benefits Program for North Carolina. The Project required PCG to educate and enroll all newly eligible and currently active Medicaid recipients into one of two (1) Health Maintenance Organizations (HMOs) or the state's Medicaid programs Access I and II. Since the initiative began in June 1996, our dedicated team of Health Benefits Advisors successfully assisted in the enrollment of approximately 355,768 Medicaid recipients. As the Health Benefits Advisor (HBA), our work included conducting multiple, daily, face-to-face education and enrollment sessions for Medicaid recipients at the local DSS offices. We also staffed a telephone hotline to process voluntary enrollment calls and inquiries from Medicaid recipients, HMOs, public health offices and other interested parties. In addition, we developed enrollment materials, outreach and educational documents, presentations, and plan comparison information for recipients. Further, PCG managed and operated multiple databases and software applications to support the State's Eligibility Information System (EIS), thereby permitting real-time managed care enrollment. Finally, HDM provided monthly statistical information to HMO's and NC DMA, including enrollment and disenrollment rosters, customer complaint logs and plan change information.

CATEGORY	STATISTICAL AVERAGE
Average Number of Calls	2229 per month
Average Number of Calls Answered	2229 per month
Percentage Calls Lost During Business Hours	2% per month
Average Time to Answer Calls	5 seconds
Average Number of Calls rolled to Queue	5.2 per month
Average Delay to Speak With an HBA	1.6 seconds

State of Maine, Health Benefits Advisory Services

Since 1998, PCG has provided Health Benefits Advisory (HBA) services to the state of Maine. In that capacity, we provide Medicaid managed care enrollment broker services to 171,000 managed care members and Medicaid Member Services for all 280,000 Medicaid members. Our scope of work has since been expanded to include Medicaid Provider Service and Medicare Part D Customer Service responsibilities. Additional amendments added to provide the Office of MaineCare Services with Medical Claims Evaluators, Provider Relations Specialists, Claims Adjusters, and Collection Specialists, and the Office of Elder Services with

Administrative Support. To successfully perform these tasks, PCG opened an office in Augusta, Maine. From this office, we operate call centers to educate and enroll Medicaid members into managed care plans, provide Member Services for all Medicaid eligible members, and to perform Provider Services for all Medicaid provider types.

State of Arizona, Customer Service and Financial Operations Center

In 2004, PCG, through its subsidiary, Public Partnerships Limited LLC (PPL), was awarded a contract by the Arizona Department of Economic Security to provide consumer-direct fiscal/employer agent services to approximately 2,000 Medicaid recipients statewide. This program is supported by a Customer Service Center and a Financial Operations Center. The Customer Service Center acts as the primary point of contact for Arizona employers and employees, as well as other states. The Customer Service Center offers bi-lingual assistance and is supported by Language Line translation and TTY services. Customer Service staff perform enrollment functions for employers and employees, and assists users with all aspects of the program, including resolving payroll and service utilization issues. Currently, the Financial Operations Center receives over 1,000 timesheets on a-weekly-basis and issues a corresponding number of payments. This highly-scalable Financial Services model was custom-designed to serve this unique population. PPL's model operates through seamless, state-of-the-art systems, including call documentation and financial management platforms which support timely payment processing and issue resolution.

Commonwealth of Massachusetts, Call Center and Financial Management Operations

In 2008, HDM, in partnership with Perot Systems Corporation (PSC), was selected by the Massachusetts Commonwealth Health Insurance Connector Authority to manage Call Center and Financial Management operations for the state's Commonwealth Care Program, a health insurance program with over 160,000 members. HDM contributes 20 of 50 FTEs to the engagement, including senior level leadership, technology and financial consulting services, as well as call center supervisory and line-level customer service representative support. With our partner, we designed, developed, and established the technology, tools, and infrastructure over an aggressive four month period, which resulted in a successful and complete transition from the previous vendor for a go-live transition on November 3, 2008. The Commonwealth Care Customer Service Center is a high-volume, high-capacity call center which supports up to 3,000 calls daily and currently achieves service levels of 97% or higher. Customer support includes comprehensive eligibility determination guidance, coaching members on premium payment requirements and account management, and referrals to other state agencies, as required. Call Center staff are trained in complex eligibility rules and premium billing support.

PCG's work on these engagements demonstrates our combined ability to provide a solid foundation for our proposed scope of work for the PEIA.

To assist the PEIA in evaluating our response we have created a question and answer format reflecting commonly asked questions about dependent eligibility audits. The questions are:

a. ***How many call center seats are supported and staffed at the present time?***

PCG currently supports a total of 71 call center seats at its three centers in Arizona (30 seats, Maine (24 seats and Massachusetts (17 seats.) We will locate the PEIA designated call center in either Massachusetts or Maine.

b. ***How are customer service representatives trained and how long does training continue before the representative takes calls?***

All customer service representatives who work in one of PCG's call centers have gone through a thorough training process. Each new representative completes a comprehensive seven day training program which is supplemented by three days of on-the-job training. During the training phase, representatives continue to work in the training lab under close supervision of the trainer. Quality assurance specialists monitor calls remotely or via side-by-side auditing. This forum allows for ample opportunity to coach and review targeted areas. The goal of OJT staff-intensive quality assurance occurs during this phase. The focus of OJT is on quality and accuracy rather than productivity. At the end of the OJT phase, with the approval of the trainers, new representatives join their peers in the call center. We can provide a more detailed description of our extensive training program upon request as it serves as a central focal point for our other call center operations.

a. ***Does your call center training program include orientation to specific requirements?***

Each of our call centers has its own individual training manual which addresses issues as simple as telephone etiquette and the phone system itself but also contains very specific technical information that covers the spectrum of topics that callers may ask about.

b. ***Can you provide dedicated or designated call center support to the PEIA's employees and dependents?***

As mentioned above, we will establish this call center from our either our Massachusetts or Maine call center sites. The call center will be staffed with a dedicated team who will answer any questions that will undoubtedly arise from this operation. Having a dedicated PEIA center will enhance the customer service experience and preserve the relationship the PEIA has with its covered members.

c. ***Will a dedicated account manager be assigned to the audit? Please describe the role and responsibilities of the account manager function.***

As we do with any of our operations, our team will designate a specific individual who will ultimately be responsible for all aspects of the operation. For this project, Nancy Pomposello, who currently serves as HDM's account manger for its PEIA relationship, will serve as your dedicated account manager. Nancy will be supported by James Herrington, HDM's Chief Marketing Officer, as well as Thomas Aldridge, a PCG Senior Manager located

in HDM's Charlotte, North Carolina office, and Kimberly Miller, an HDM project manager. All three of Nancy's support team has extensive knowledge of PEIA practices and philosophy.

d. *How many letters are used in your audit service?*

As our work plan describes, our audit process typically involves three letters -- an initial letter plus two follow-up letters for those who have not responded or not responded satisfactorily. If the PEIA has its own ideas about the content, frequency, and number of letters, we will work together to develop an alternative approach to communicate as effectively as possible with employees and their dependents.

e. *Are reminder/deadline approaching mailings included in your service?*

As mentioned above, our standard process includes two follow-up letters for those who have not satisfied the document request requirements. This is another situation where our methodology can be modified if the PEIA prefers an alternative approach.

f. *Can the PEIA specify the audit documentation requirements for each of its dependent types and subtypes?*

We certainly welcome input as to the documentation requirements. Our standard process uses proven audit tools and methods, however, alternative approaches and alternative forms of documentation can certainly be incorporated into the overall audit protocols.

g. *Does your system have a limit as to the number of audit documents?*

The Dependent Eligibility Auditor™ application proposed for this engagement has been successfully tested to 100,000 subscriber/dependent records per license. If necessary, additional licenses may be purchased as necessary to accommodate a higher volume of documents.

h. *Describe your backup cycles for live application and data archiving purposes.*

PCG maintains strict IT operations protocols for the live application and data archiving. The application and historical data is stored in a dedicated SQL Server environment. Data is preserved by backup to the data center on a nightly basis; as of end-of-day restores are possible for one week (possibly up to two weeks). At the end of each week, data is preserved by sending a tape from the data center to an offsite location; as of end-of-previous-week restores are possible through the beginning of the current calendar quarter. Similarly, at the end of each quarter, data is preserved by retaining the last weekly tape from the quarter, but recycling the rest; as of end-of-previous quarter restores are possible through the beginning of the current calendar year. Further, at the end of each calendar year, data is preserved by retaining the last tape from the year, but recycling the rest; as of end-of-previous year restores are possible for the previous calendar year. Although prior year's data is not officially retained, in practice the backup tape sets from years prior to the last calendar year have not been discarded; if a business unit requires additional time for retention, they should explicitly make the request.

i. Describe the PEIA's level of system access for those PEIA personnel involved in the audit.

Our dedicated team will work with the PEIA to determine the level of access needed by PEIA personnel. If desired, we can build an interface to the software that will allow an electronic load of the audit documentation. We will certainly establish security safeguards allowing access to the individual client records to those PEIA personnel designated to have this level of clearance. Our team will outline all of this during the introductory phase of this project and ensure access is granted to those who need it and limited to those who do not.

The dedicated call center will also allow employees and dependents to submit their documentation via a secure web-based solution. Given the volume of documentation that this audit will generate, it will be important to receive documents electronically and properly file and store them. We understand this necessity because of our extensive call center experience and, in fact, have the capability and the in-house resources to offer it.

SECTION VI: DEA PROJECT PLAN & TIMELINE

With already established presence in serving PEIA with an experienced project team and the technological and human resources already in place, we are confident of our ability to efficiently implement a comprehensive and value driven Dependent Eligibility Audit project for the PEIA.

HDM and PCG have worked together to prepare a balanced work plan with both an aggressive implementation timeframe combined with a comprehensive set of tasks. At a high level, we have identified the events and the sequence of those events as follows:

1. Project Kick-Off and Communication Plan
2. Eligibility Data Transfer
3. Establishment of Call Center Operation
4. Amnesty Notification
5. Dependent Eligibility Audit (i.e., document requests sent out, documents received, analyzed, etc.)
6. Final Audit Report
7. Documentation Transfer

A more detailed breakdown of the timeframe and tasks required to complete the project can be found on the following page. We expect that the audit will take approximately 120 days from the kick-off meeting to the transfer of documentation from the HDM/PCG Team to the PEIA.

SECTION VII: ADDITIONAL SERVICES

HDM and PCG bring an expanded scope of services to each health plan engagement including disability determinations for Medicare eligibility enrollment, claims review and PBM contract management yielding incrementally more cost savings than the Dependent Eligibility Audit alone.

Our joint efforts bring forth an entire spectrum of services for health plans that go above and beyond dependent eligibility audit. These projects focus both on eligibility to find members who may qualify but who are not yet enrolled in other health programs (i.e., Medicare) and claims management including identification of potential overpayments and other revenue initiatives.

As an example of one of these projects, we propose the following additional scope of work for this engagement:

Benefit Optimization Strategic Services (BOSS)

Employee health plans are paying primary for individuals whose healthcare costs should be reimbursed by Medicare due to the recipient's disabled status. Specifically, these members have either lost or have never established their Medicare eligibility and are not properly enrolled in the program. Diagnoses such as End Stage Renal Disease (ESRD), ALS, HIV/AIDS, and liver disease represent opportunities to qualify recipients for SSI, SSDI and/or Medicare enrollment. HDM will extract both the claims and eligibility information and perform a comprehensive data analysis of the disabled and over 65 populations to identify employee health plan members eligible for Medicare benefits, assist the members with the enrollment process and develop and implement a strategy to recover health plan payments for which Medicare should have been the primary payer. By identifying and enrolling these members, the health plan will avoid the cost of future medical care for these members and recognize significant retroactive cost recovery if retroactive eligibility is established. On average, members with chronic conditions cost the health plan approximately $20,000 in annual health costs. By shifting the primary responsibility to Medicare, the net cost to the health plan is reduced to approximately $3,000 in coinsurance and deductible costs. By qualifying 500 chronically disabled members, the health plan can realize a cost savings of an estimated $17,000 per member equating to $8.5 million in annual savings for the health plan (500 members x $17,000 net cost savings).

SECTION VIII: ENROLLMENT RECONCILIATION ANALYSIS

We will work with each of the nearly 600 non-state agencies, as well as the 200 estimated state agencies to determine that each agency is compliant with the criteria established for determining whether a policyholder is eligible for participation for coverage in the PEIA benefits program.

Our proposal assumes that each agency will provide a file of employees (principally electronic) on the payroll of the agency, thereby allowing HDM to compare PEIA's enrollment files to the agency's payroll records. The purpose is to determine that every policyholder on the PEIA enrollment files appears on the payroll of an agency participating in the PEIA program.

We understand that the PEIA expects compliance with this audit from each agency. However, since without precise knowledge of the level of participation, the actual number of electronic payroll comparisons to be performed, the size of each file, etc., our pricing for this project assumes a significant amount of manual intervention in completing this review.

SECTION IX: TOBACCO-FREE PREMIUM DIFFERENTIAL AUDITS

Through the use of the same technology and audit processes now familiar to PEIA staff, we will compare the entire claims file of those individuals receiving the discounted tobacco-free premium differential to surface evidence of possible tobacco use.

This analysis will be accomplished by matching all claims for each individual against a file containing those diagnostic and procedural codes and illnesses most commonly associated with tobacco use. We will need a minimum of two years and perhaps as many as four years of claims and eligibility information for those individuals subject to the premium discount.

We will also look for evidence an individual has used benefits available to assist in quitting the use of tobacco products, including a review of their physician office visit history, purchases of nicotine patches and similar products, and all other over the counter tobacco cessation products. Combining this information with medical claims history will produce the list of those members requiring further investigation.

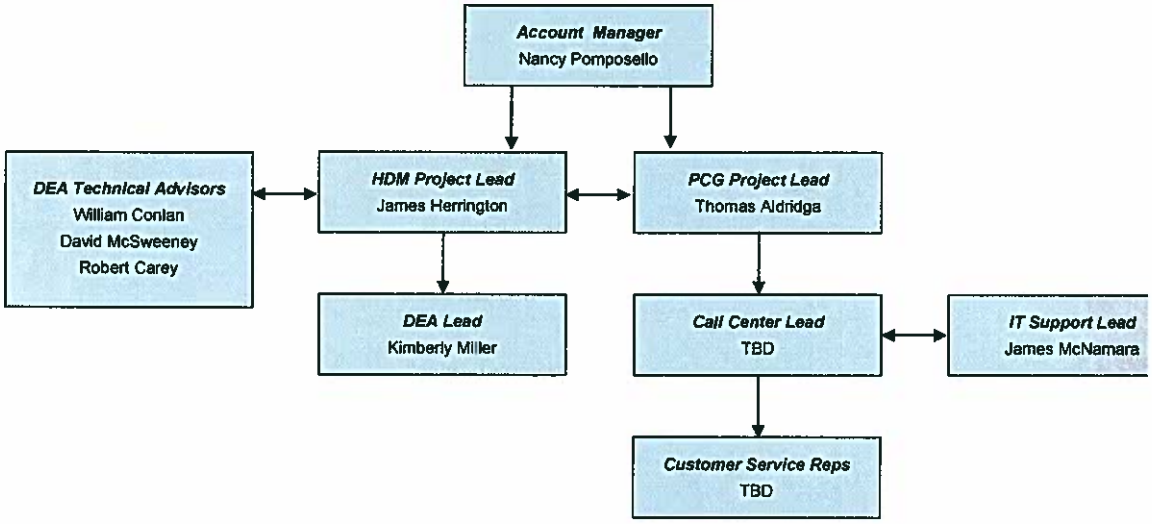
Our report of possible matches of individuals to claims data suggesting a possible relation between the claims and tobacco use will, by definition, require further specific clinical investigation by the PEIA. We understand our obligation to be limited to the identification of enrollees with claims that, again, may possibly be linked to tobacco use. Naturally, we will need to work with PEIA staff to ensure that all information shared on members complies with the HIPAA regulations.

SECTION X: PROJECT STAFFING

We are committed to staffing this project with professionals who have the skills, knowledge, and understanding to perform a successful DEA audit. We also expect to leverage the broad experiences of several technical advisors.

Our project team is made up of a seasoned group of professionals with experience across the healthcare spectrum. In addition to the individuals who will staff the project, there are several technical advisors who, we believe, bring additional expertise to bear on this engagement. The group includes some very senior members of HDM and Robert Carey, an independent contractor that HDM has engaged to advise our project team on this project.

HDM/PCG Project Team & Organization



Project Team

Nancy Pomposello, is well known to the staff at PEIA and a subject matter expert in the healthcare field; as a manager, consultant, licensed multi-state producer and Registered Nurse. Nancy has many years of expertise designing benefit plans for clients, pharmaceutical and disease management, project management, as well as building networks suitable for clients and prospects. Nancy brings both administrative and clinical skills to the client, member and the industry.

Her experience as a Manager for Taft-Hartley Funds and corporate clients on a national basis, positions her extraordinarily well for the diverse challenges presented by a client as large and complex as the PEIA.

Her professionalism, efficient approach to tasks, and extensive knowledge of the PEIA program, culture and objectives will provide great benefit to this engagement.

James Herrington, HDM's Chief Marketing Officer, will serve as the HDM project lead on this engagement. Mr. Herrington has more than 30 years experience in managed care and management consulting and is an accomplished senior executive with significant experience in sales management, business Development, communications, advertising, product Development, and marketing operations with a broad knowledge of health delivery systems, markets, and health economics. Previous to joining HDM, Herrington served as Chief Marketing Officer for Private Healthcare Systems, Chief Marketing Executive for National Account Service Company, LLC (NASCO), Vice President for Sales and Marketing for Peer Review Analysis, Inc., Director of East Region Health and Welfare Practice for Ernst and Young, LLP after 14 years with Blue Cross Blue Shield of Massachusetts in various marketing and account management roles. As Chief Marketing Officer at HDM, Herrington oversees all sales, marketing and account management functions.

Thomas Aldridge, a Manager located in our Charlotte, North Carolina office, has more than ten years of experience with HDM and thirteen years in the healthcare financial services arena. Mr. Aldridge is the current manager for our revenue maximization engagements in North Carolina and West Virginia and is additionally serving as a member of our revenue maximization project team with several other engagements. Mr. Aldridge has also managed several Third Party Liability (TPL) projects and initiatives on behalf of HDM, including the TPL project in the State of Louisiana, the MSP project for CMS and several Medicaid HMO clients. His experience includes Medicaid, mental health, public health, and child welfare initiatives encompassing the areas of accounts receivable, accounts payable, MIS, billing compliance, DSH, family planning, claims review, Upper Payment Limits (UPL) and mental health facilities in addition to numerous other revenue enhancement initiatives. In addition, he played an extensive role in HDM's study of North Carolina's Mental Health, Developmental Disabilities, and Substance Abuse (DMH/DD/SA) delivery system through the Office of the State Auditor identifying areas of revenue improvement and cost savings for the State. Each of these projects requires expertise in both operational and financial analysis to optimize revenue and determine the most efficient means of providing quality services to the client population. Before joining HDM, Mr. Aldridge served as a physician practice services manager for a large physician management company in Macon, Georgia. Mr. Aldridge received his Bachelor of Arts in Economics from Clemson University and completed a Master's Degree in Healthcare Administration (MHA) at the University of North Carolina at Chapel Hill.

Kimberly Miller, a Project Manager with HDM, has over 13 years of diverse experience in the health care industry. After earning her Bachelor degree from Morgan State University, Master Degree of Science in Health Administration, and Master Degree of Science in Health Education from St. Joseph's University in Philadelphia, PA she began her career as a Provider Services Representative with Independence Blue Cross (IBC). In 2000, Miller became Unit Manager at Devon Manor, a Long Term Care Facility where she managed the direct care staff and was responsible for compliance for state and federal guidelines. Miller was responsible for coordinating and supervising all scheduled patient care conferences between patients and family members as well as training and in service of staff. Prior to joining HDM, Miller served as Admission Director for Inglis House and managed the day to day operations of the admission department. As Project Manager at HDM, Miller is responsible for overseeing all phases of projects, including planning, directing, and completing all audit projects.

James McNamara, the Chief Technology Officer of PCG's Strategy & Finance Practice Area, will provide IT support for the DEA software package that we will employ on this engagement. Mr. McNamara is responsible for creating software products and deploying information technology solutions that support the mission of PCG's customers. Mr. McNamara has over 20 years of software technology experience working for health care, government, and other public and private sectors. He is a member of the Association for Computing Machinery and the Project Management Institute, where he is a certified Project Management Professional (PMP). He earned his M.S. in Computer Information Systems and his B.S. in Computer Science, both from Boston University.

Technical Advisors

William Conlan, HDM's CEO, will be one of our key technical advisors on the project. Mr. Conlan founded HDM in 1992 and is responsible for conceiving, designing and Developing the BenefitsAudit software program into the successful national business it is today. With over 18 years of extensive experience in medical billing, auditing services and data management in the healthcare industry, Mr. Conlan is a well-accomplished entrepreneur with a variety of business experiences and skills, including developing and commercializing technology, strategic planning, and business management. It was Mr. Conlan's previous experience in the medical billing industry that additionally helped him gain in-depth knowledge of the most common areas of billing mistakes, fraud, and intimate knowledge of the billing procedures of the industry. As CEO of HDM, Mr. Conlan is responsible for business and product Development, strategic management and marketing. He designed and led the HDM technical team to develop BenefitsWatch and led the company with sales growth doubling the last two consecutive years. Conlan earned a Bachelor of Science Degree in marketing from the University of Richmond and a Master of Business Administration Degree in finance from American University.

Robert Carey, an independent contractor, has been engaged with HDM to serve as technical advisor on several of our engagements. Mr. Carey is a health and welfare benefits advisor who specializes in benefits management, analytics and design, and health and welfare vendor procurements. Mr. Carey was most recently employed as the Director of Planning and Development for the Commonwealth Health Insurance Connector Authority, an independent authority established pursuant to Massachusetts' landmark health reform law. In this role, Mr. Carey implemented new health insurance programs, including designing public and commercial health benefit plans, as well as Developing health care financing arrangements. Mr. Carey also served for several years as the Director of Policy and Program Management for the Massachusetts Group Insurance Commission, the state agency responsible for providing health and welfare benefits to over 265,000 state employees, retirees and their dependents. His work experience includes senior research and policy positions with non-governmental research organizations and government oversight boards, as well as policy positions with the U.S. Congress and the Maine Legislature. Mr. Carey received an M.S. degree in public policy and management with a concentration in economics from Carnegie Mellon University and a B.A. in English from the University of Maine at Fort Kent.

David McSweeney, Chief Operating Officer of HDM, will serve as one of the project's technical advisors. Mr. McSweeney has over 30 years experience as a financial and operations executive, for a variety of well-known healthcare organizations, demonstrating

exceptional leadership skills and gaining extensive P/L responsibility in group health insurance, HMO's, PBM's, TPA's, and all facets of employee benefits. Mr. McSweeney served as Director of Claims for Blue Cross Blue Shield of Massachusetts for over 10 years before becoming Vice President for Blue Shield of New Jersey. Mr. McSweeney then moved to New Jersey Delta Dental where he successfully reduced overall administrative cost by $40 million and introduced new health insurance and dental products that increased medical and dental premiums. Mr. McSweeney next became Southwestern Regional Vice President for United Healthcare where he was responsible for the Development, licensure and operations, and profitability of a three state HMO achieving revenues of $100 million. His rising career led Mr. McSweeney to serve as President and Chief Operating Officer for Alternative Dental Care Inc., a wholly-owned subsidiary of Lincoln National Life Insurance, followed by founding and serving as President and Chief Executive Officer for Vienna Corporation, a privately-held company that provided strategic consulting services to healthcare corporations, Fortune 100 companies, and the pharmaceutical industry. Concurrently, Mr. McSweeney co-founded and was President of American Healthfund, an asset-based finance company providing capital for equipment leasing, working capital, and debt restructuring to profit and not-for-profit institutional and professional healthcare providers. Prior to joining HDM, Mr. McSweeney served as President and COO of Claims Administration Corporation, a wholly-owned subsidiary of CNA, where he led a $2.2 billion group healthcare and benefits enterprise. Now as COO at HDM, Mr. McSweeney is responsible for the strategic business Development, market analysis, and the further refinement and Development of the BenefitsAudit service and HDM enterprise data warehouse. He is additionally accountable for recruiting and overseeing the performance of audit, support and operations staff. Mr. McSweeney holds a Bachelor of Arts Degree from the University of Massachusetts and has completed coursework for MPH at the Boston University School of Public Health as well as the Executive Education Program in health care management from the University of Michigan.

SECTION XI: REFERENCES

The following individuals may be contacted regarding work performed by HDM and PCG.

PCG

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SECTION XII: PRICING

This section of the response summarizes HDM's proposed pricing. Pricing is based on our ability to meet all of the PEIA's compliance and financial objectives for the project within the timeframes specified. HDM recognizes the financial importance of this project to the PEIA in light of the current economic climate and other budgetary constraints. Our proposed work plan leverages technology and human resource expertise to drive even greater savings. While this project requires technology solutions that accommodate large volume processes (e.g., scanning and electronic storage of thousands of documents), it also requires the ability to implement and facilitate human resource solutions when technology is not cost effective or practical (e.g., manual indexing of documents to ensure accuracy). HDM's work plan and pricing proposal provide the optimal mix of technology and human resources to ensure that PEIA goals are achieved in a timely, accurate and cost effective manner.

	Implementation/Enrollment Reconciliation Analysis and Dependent Eligibility Audit	**Fixed Fee**	**Basis**
a.	Enrollment Reconciliation Analysis Design, Development & Implementation (DDI)	$1.10	Per Policyholder @ 107,000 policyholders
b.	Dependent Eligibility Audit Design Development & Implementation (DDI) (Includes Tobacco-free premium analysis and third-party liability audits)	$2.87	Per Member @ 209,600 members

All fees pertaining to this quotation, including postage at first-class rates, are included in our fixed fees.

We are certainly willing to perform additional work to recover claims from either the liable third party (i.e., the TPA who should have verified the eligibility status of the dependent) or directly from the member if, in fact, that is the course of action desired by the PEIA. Because the scope of work for this work has not been defined, we will reserve proposing a fee until further clarification in the desired tasks is discussed with the PEIA. If no agreeable fee is negotiated, the HDM/PCG Team will assist PEIA in identifying other possible vendors to perform the requested work.